POLICY 4.5 – Terms of Reference for the Board Quality Committee

Interior Health would like to recognize and acknowledge the traditional, ancestral, and unceded territories of the Dãkelh Dené, Ktunaxa, Nlaka'pamux, Secwépemc, St'át'imc, Syilx, and Tŝilhqot'in Nations, where we live, learn, collaborate and work together.

Interior Health recognizes that diversity in the workplace shapes values, attitudes, expectations, perception of self and others and in turn impacts behaviors in the workplace. The dimensions of a diverse workplace includes the protected characteristics under the human rights code of: race, color, ancestry, place of origin, political belief, religion, marital status, family status, physical disability, mental disability, sex, sexual orientation, gender identity or expression, age, criminal or summary conviction unrelated to employment.

1.0 PURPOSE

1. The Quality Committee (the "Committee") will assist the Board of Directors (the "Board") to ensure that the quality of patient, client and resident care meets an acceptable standard throughout the Interior Health Authority (the "Authority") by:

   a. ensuring the President and Chief Executive Officer (the "CEO") establish a strategic quality plan that supports the development of a performance based quality improvement culture;

   b. ensuring the Authority has in place appropriate operational plans to allow the organization to meet service requirements set out by the Ministry of Health (the "Ministry");

   c. ensuring that the Authority meets the requirements for all accrediting organizations with which the Authority engages;

   d. ensuring that the activities of the Committee are aligned with other broad strategic goals set out by the Audit & Finance and Governance & Human Resources Committees; and

   e. providing support, input and governance to the CEO and the Health Authority Medical Advisory Committee ("HAMAC") as they establish performance targets, standards of care and service, and guidelines and policies for patients, clients and residents.

2.0 COMPOSITION & OPERATIONS

1. The Committee shall be composed of not fewer than three (3) directors and may include the full Board of Directors.
2. The Committee shall operate in a manner consistent with the Committee Guidelines Board Policy 4.1.

3. The Committee shall be formally approved by the Board as a quality assurance committee protected under Section 51 of the Evidence Act (the "Act") as outlined in Appendix A.

3.0 DUTIES & RESPONSIBILITIES

The Committee will:

1. review with the CEO, key measures and indicators, including those identified by the Ministry to assess the quality of patient, client and resident services provided by the Authority;
2. receive, review and make recommendations on reports from the CEO and Vice President for Quality on issues related to:
    a. review and approve Quality & Patient Safety Plan;
    b. clinical service delivery and relevant performance monitoring;
    c. patient client and family experience feedback and survey results;
    d. receive and review reports from the Patient Care Quality Office that identify any major issue or priority that needs to be addressed; and
    e. monitor accreditation activities including readiness for accreditation surveys and compliance with all applicable standards;
3. regularly review reports prepared by, Internal Audit, and external third parties to monitor the quality of care being provided, patient outcomes, and patient satisfaction, observe trends, and identify areas where further investigation may be warranted;
4. recommend that the Board request the CEO to conduct specific quality reviews where necessary;

Other Duties

5. review terms of reference including the attached appendices and schedules for the Committee and make any recommendations for changes to the Governance & Human Resources Committee; and
6. undertake any special initiatives requested by the Board or the Board Chair.
7. Review Board Policies outlined in Appendix D and make recommendations to the Board of Directors for any revisions needed.

4.0 RISK MANAGEMENT

The Committee will:

1. as required, receive updates with respect to categories of risk for which the Committee is directly concerned;

2. receive from time to time independent reports of the Internal Auditor;
3. keep the Board informed of any major incidents; and
4. from time to time, recommend to the Board any changes in policy or process required to achieve the overall objectives of the Authority's risk management program.

5.0 ACCOUNTABILITY

The Committee shall report its deliberations to the Board by maintaining minutes of its meetings and providing an oral report at the next Board meeting.

6.0 COMMITTEE TIMETABLE

The work of the Committee will be guided by a Timetable (Appendix B) which will be reviewed at least annually. The timetable will have a number of standing reports, but the Committee, at its discretion, may request reports or analysis as appropriate and in alignment with the Terms of Reference of the Committee.

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APPENDIX A – SECTION 51 OF THE EVIDENCE ACT

1.0 IMPLICATIONS OF THE EVIDENCE ACT

1. Section 51 of the Evidence Act (the "Act") provides that records and information arising out of quality assurance activities in hospitals are privileged and are not subject to the Freedom and Information and Protection of Privacy Act (FOIPPA) other than Sections 44(1)(b), 44(2), 44(2.1) and 44(3) of the FOIPPA.

2. Within the Act, quality assurance is the component of the system related to care provided to patients, residents and clients by health professionals as defined in the Health Professions Act or other persons registered as a member of a College established under the Act.

3. The Act protects the quality assurance of hospitals as defined in the Hospital Act, the Hospital Insurance Act and the Mental Health Act. This includes private and non-profit:
    a. acute care hospitals;
    b. convalescent and rehabilitation hospitals and units;
    c. mental health facilities and psychiatric units; and
    d. private nursing homes where two or more patients, other than the spouse, parent, child of the owner or operator, are living at the same time.

4. To qualify under Section 51, a hospital must comply with the specific set of rules laid out in the Act.

5. Only those documents and deliberations specifically prepared by or for a quality assurance Committee are protected under Section 51 of the Act. It will be the responsibility of management to ensure that it is made clear on the face of the document that it was created for ultimate submission to the Committee e.g. marked "Confidential – Quality Committee".

6. With the exception of quality assurance activities within the scope Section 1(3) above, the quality assurance activities of Community Care, Mental Health and Substance Use, Population Health and Wellness, and Residential Services are not protected by the Act. These programs may, however, be exempted from disclosure under certain segments of the FOIPPA. In circumstances where, in the opinion of management, the activities reasonably fall within the exemptions provided by the FOIPPA, any reports to the Committee should again be marked "Confidential – Quality Committee".

7. The Quality Committee should have an in-camera agenda for quality assurance and FOIPPA exempted items and, if necessary, a regular agenda for any other issues and reports.

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While business conducted within Committees is not open to public participation, the Minutes of the Board may be. In these circumstances, the reports of the Quality Committee on an in-camera agenda must be so identified and presented to the Board only when the Board is in camera.

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APPENDIX B – COMMITTEE TIMETABLE

Terms of Reference Section and Activity	Fiscal Year					
	Apr	June	Oct	Dec	Feb	As Required
1. review with the CEO, key measures and indicators, including those identified by the Ministry to assess the quality of patient, client and resident services provided by the Authority						X
2. receive, review and make recommendations on reports from the Vice President for Quality on issues related to:						
a. Quality & Patient Safety Plan		X				
b. clinical service delivery and relevant performance monitoring – as outlined in Appendix 3	X	X	X	X	X	
c. patient client and family experience feedback and survey results		X				X
d. review management reports with of clinical service evaluations, unusual occurrences and concerns						X
e. receive and review reports from the Patient Care Quality Office to identify any major issue or priority that needs to be addressed	Status Update: Learning & Recommendations from Patient Safety	Critical Incidents	Patient Safety	Critical Incidents	Patient Safety	
f. monitor accreditation activities including readiness for accreditation surveys and compliance with all applicable standards						X

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Terms of Reference Section and Activity	Fiscal Year					
	Apr	June	Oct	Dec	Feb	As Required
3. Regularly review reports prepared by, Internal Audit, and external third parties to monitor the quality of care being provided, patient outcomes, and patient experience, and identify areas where further investigation may be warranted						X
4. Recommend that the Board request the CEO to conduct specific quality reviews where necessary						X
5. Review terms of reference and any accompanying appendices and schedules and make any recommendations for changes to the Governance & Human Resources Committee		X				
6. Undertake any specific initiatives requested by the Board or the Board Chair						X

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APPENDIX C – NETWORK/PROGRAM PRESENTATION SCHEDULE

Stroke	June 2025
Laboratory Services	June 2025
Cardiac Services	October 2025
Surgical Services	October 2025
Maternal, Newborn, Child & Youth	December 2025
Emergency Services	December 2025
Critical Care	February 2026
Renal Services	February 2026
Pharmacy Services	April 2026
Seniors' Care	April 2026
Cancer Care	June 2026
Medical Imaging	June 2026
Trauma Services	October 2026
MHSU	October 2026
Stroke	December 2026
Laboratory Services	December 2026

The presentations are based on the Quality Matrix and should:

1. Summarize network/program work; focusing on key achievements;
2. Describe any critical impediments faced by the program/network in delivering on service quality;
3. Highlight one improvement initiative that was completed, or in which significant progress has been made;
4. Reflect the alignment of the work to a service plan as applicable; and
5. Highlight how the patient/family/community voice has been considered in the work; leaders may invite a project team member and/or patient/family representative to speak at the meeting.

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APPENDIX D – POLICY REVIEW TIMETABLE

Policy		Apr	June	Oct	Dec	Feb
3.18	Research Ethics (Every 3 Years)				X 2025	
3.19	Research (Every 3 Years)					X 2026
4.4	Terms of Reference for the Quality Committee (Annually)		X			

**Board policies may be reviewed outside of this timetable as needed.*